MEDICAL RECORD	Orders Manual: Chronic Granulomatous Disease

Date: _____ **Case Manager**: ☐Dirk ☐Mary ☐Sandra **LIP**: ☐Holland ☐Malech

Date of NIH Visit:

Monday	Tuesday	Wednesday	Thursday	Friday

Please record all appointments and times on the CGD preplanning log sheet.

Labs/Phlebotomy *(always schedule at 8:00 am on first day of visit, unless instructed differently by case manager)*:

Other Tests:

☐**Chest CT: 6-6681**
Indication: CGD Patient, protocol mandated
Approximate time for test:_____AM _____PM *Scheduled time*:_____AM/PM
Will the patient need contrast? ☐Yes ☐No
If yes, ☐Oral ☐IV ☐Both

☐**Chest/Abdomen/Pelvis CT: 6-6681**
Indication: CGD Patient, _____
Approximate time for test:_____AM _____PM *Scheduled time*:_____AM/PM
Will the patient need contrast? ☐Yes ☐No
If yes, ☐Oral ☐IV ☐Both

☐**Chest and Neck CT: 6-6681**
Indication: CGD Patient, _____
Approximate time for test:_____AM _____PM *Scheduled time*:_____AM/PM
Will the patient need contrast? ☐Yes ☐No
If yes, ☐Oral ☐IV ☐Both

☐**MRI: 6-6681**
MRI of: ☐Abdomen ☐Brain ☐Chest ☐Face/Sinuses/ENT
☐Kidneys ☐Liver/Spleen ☐Neck ☐Other:_____
Indication: CGD Patient, _____
Will the patient need contrast? ☐Yes ☐No
Does the patient have: ☐Pacemaker or Autodefribillator ☐Cochlear Implants
☐Foreign body in the eye ☐Surgical clips or aneurysm
Scheduled time:_____AM/PM

☐**Pulmonary Function Tests (PFTs): 6-6681**
(This test takes approximately 1.5-2 hours to complete. The patient needs to arrive at 7W 15 minutes ahead of scheduled appointment time.)
In MIS, select "Bronchodilator study with routine pulmonary function study." Also select "Other" and type in "Pre and post bronchodilator."
Indication: CGD Patient, protocol mandated
Medications:

☐**Dermatology Consult: 6-6421, OP13** (The patient should be scheduled to see Dr. Turner. If unable to, notify the case manager.)
Has this patient been seen before? ☐Yes ☐No
Medications:

Date:_____ *Time*:_____

☐**Neurology Consult: 6-8033, OP7** (Neurology clinic is held on Wed. afternoons. Please schedule patient with Dr. Karp. If unable to, notify the case manager.)
Has this patient been seen before? ☐Yes ☐No
Medications:

Date:_____ *Time*:_____

Other Tests/Procedures:_____

LIP Signature	LIP Name (printed)	Date